FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0033779

Facility Name: Covenant Health Care Center-Northbrook

Address: 2155 Pfingsten Road (Number) Northbrook (City) 60062 (Zip Code)

County: Cook

Telephone Number: 847-480-6380 **Fax #** 847-480-7666

IDPA ID Number: 52-1115873001

Date of Initial License for Current Owners: 01/20/72

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Linda Davis **Telephone Number:** 773878-2295 Ext 826

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 02/01/2003 to 01/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Elizabeth Buikema
(Title) Vice President/CFO

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/2003 Ending: 01/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	102	Skilled (SNF)	102	37,230	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	64	Sheltered Care (SC)	64	23,360	5
6		ICF/DD 16 or Less			6
7	166	TOTALS	166	60,590	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,448	23,979	1,800	34,227	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		18,198		18,198	12
13	DD 16 OR LESS					13
14	TOTALS	8,448	42,177	1,800	52,425	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.52%

D. How many bed-hold days during this year were paid by Public Aid?
none (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meal on wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 01/20/72

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 102 and days of care provided 1,800

Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 01/31/03 Fiscal Year: 01/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/2003 Ending: 01/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	424,557	59,350	20,223	504,130		504,130	(21,022)	483,108			1
2	Food Purchase		410,527		410,527		410,527		410,527			2
3	Housekeeping	187,580	26,310	5,374	219,264		219,264		219,264			3
4	Laundry	24,166	13,786	118,780	156,732		156,732		156,732			4
5	Heat and Other Utilities			224,569	224,569		224,569		224,569			5
6	Maintenance	111,500	62,109	128,887	302,496		302,496		302,496			6
7	Other (specify):*											7
8	**TOTAL General Services**	747,803	572,082	497,833	1,817,718		1,817,718	(21,022)	1,796,696			8
	B. Health Care and Programs											
9	Medical Director			24,420	24,420		24,420		24,420			9
10	Nursing and Medical Records	2,694,932	117,275	14,120	2,826,327		2,826,327		2,826,327			10
10a	Therapy	48,126		132,392	180,518		180,518		180,518			10a
11	Activities	143,787	8,055	8,185	160,027		160,027		160,027			11
12	Social Services	140,245	14,110	1,700	156,055		156,055		156,055			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,027,090	139,440	180,817	3,347,347		3,347,347		3,347,347			16
	C. General Administration											
17	Administrative	131,620		422,568	554,188		554,188		554,188			17
18	Directors Fees											18
19	Professional Services			59,421	59,421		59,421		59,421			19
20	Dues, Fees, Subscriptions & Promotions			26,554	26,554		26,554	(14,224)	12,330			20
21	Clerical & General Office Expenses	252,599	38,329	226,106	517,034		517,034	(242,898)	274,136			21
22	Employee Benefits & Payroll Taxes			931,128	931,128		931,128	(11,043)	920,085			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,595	5,595		5,595	(3,013)	2,582			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			149,623	149,623		149,623		149,623			26
27	Other (specify):*											27
28	**TOTAL General Administration**	384,219	38,329	1,820,995	2,243,543		2,243,543	(271,178)	1,972,365			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,159,112	749,851	2,499,645	7,408,608		7,408,608	(292,200)	7,116,408			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Covenant Health Care Center-Northbrook #0033779 Report Period Beginning: 02/01/2003 Ending: 01/31/2004

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			434,342	434,342		434,342	(71,282)	363,060			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(6,936)	(6,936)		(6,936)	6,936				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			427,406	427,406		427,406	(64,346)	363,060			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		497,804		497,804		497,804		497,804			39
40	Barber and Beauty Shops	46,500	1,167		47,667		47,667		47,667			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,845	55,845		55,845		55,845			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	46,500	498,971	55,845	601,316		601,316		601,316			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,205,612	1,248,822	2,982,896	8,437,330		8,437,330	(356,546)	8,080,784			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/2003 Ending: 01/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(71,282)	30		9
10	Interest and Other Investment Income	6,936	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(500)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (64,846)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (64,846)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Covenant Health Care Center-Northbrook

ID# 0033779

Report Period Beginning: 02/01/2003

Ending: 01/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Employee Recognition	$ (11,043)	22	1
2	Marketing	(6,593)	20	2
3	Benevolent Care Expense	(241,928)	21	3
4	Telephone Revenue	(470)	21	4
5	Meals Revenue	(21,022)	1	5
6	Non allowable travel and seminar	(3,013)	24	6
7	Non allowable dues and subscribtions	(7,631)	20	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(291,700)		49

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Summary A

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 **Report Period Beginning:** 02/01/2003 **Ending:** 01/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(21,022)	0	0	0	0	0	0	0	0	0	0	(21,022)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(21,022)	0	0	0	0	0	0	0	0	0	0	(21,022)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(14,224)	0	0	0	0	0	0	0	0	0	0	(14,224)	20
21	Clerical & General Office Expenses	(242,898)	0	0	0	0	0	0	0	0	0	0	(242,898)	21
22	Employee Benefits & Payroll Taxes	(11,043)	0	0	0	0	0	0	0	0	0	0	(11,043)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,013)	0	0	0	0	0	0	0	0	0	0	(3,013)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(271,178)	0	0	0	0	0	0	0	0	0	0	(271,178)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(292,200)	0	0	0	0	0	0	0	0	0	0	(292,200)	29

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Summary B

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 **Report Period Beginning:** 02/01/2003 **Ending:** 01/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(71,282)	0	0	0	0	0	0	0	0	0	0	(71,282)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	6,936	0	0	0	0	0	0	0	0	0	0	6,936	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(64,346)	0	0	0	0	0	0	0	0	0	0	(64,346)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(356,546)	0	0	0	0	0	0	0	0	0	0	(356,546)	45

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/2003 Ending: 01/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
NA						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/2003 Ending: 01/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/2003 Ending: 1/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Covenant Retirement Communities
Street Address: 5115 N. Francisco
City / State / Zip Code: Chicago, Illinois 60625
Phone Number: (773) 878-2294
Fax Number: (773) 8782289

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Management Fees	Net Service Revenue		32	$ 5,691,819	$ 2,322,686		$ 422,568	1
2	19	Data Processing	fixed Fee Per Mon		32	772,884	21,468		21,468	2
3	19	Audit Services	fixed Fee Per Mon		32	312,974	12,653		12,653	3
4	19	Cost Report Prep	fixed Fee Per Mon		14	60,960	5,855		5,855	4
5	19	Payroll Services	Dir Costs				10,324		10,324	5
6	22	Pension	Dir Costs				14,184		14,184	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,838,637	$ 2,387,170		$ 487,052	25

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/2003 Ending: 01/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	1998 TE Term Bonds		x			1/98	$	$	12/1/15	variable	$ 9,228	1
2	1998 T/E 5 year term bonds		x			1/98			12/1/15	variable	33,194	2
3	2002 Tax EX bonds		x			1/2002			12/1/15	variable	190,732	3
4												4
5												5
	Working Capital											
6	CRC Interco Notes	x		Working Capital							60,965	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 294,119	9
	B. Non-Facility Related*											
10	INTEREST ADJUSTMENT										(294,119)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (294,119)	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 **Report Period Beginning:** 02/01/2003 **Ending:** 01/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003		12

TAX BILL NO LONGER APPLIES TO SKILLED OR ASSISTED FACILITIES

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1200.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Covenant Health Care Center-Northbrook COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0033779

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/2003 Ending: 01/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 77,894 B. General Construction Type: Exterior Brick-masonary Frame Steel Studded Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1973	$ 70,272	1
2					2
3	TOTALS			$ 70,272	3

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/2003 Ending: 01/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	166		1974	1974	$ 1,467,406	$	40	$ 36,685	$	$ 1,118,897	4
5			1975	1975	2,250		40	56		1,659	5
6			1976	1976	1,916		40	48		1,365	6
7			1977	1977	2,769		40	69		1,903	7
8			1978	1978	7,643		40	191		5,063	8
	Improvement Type**										
9	Building Improvements - Brandel Care Center			1979	18,220		40	455		11,614	9
10	Building Improvements - Brandel Care Center			1980	20,844		40	521		12,767	10
11	Building Improvements - Brandel Care Center			1981	38,116		40	953		22,393	11
12	Building Improvements - Brandel Care Center			1982	3,360		40	50		1,032	12
13	Building Improvements - Brandel Care Center			1984	13,999		40	350		7,099	13
14	Building Improvements - Brandel Care Center			1985	162,076		40	4,502		87,525	14
15	Building Improvements - Brandel Care Center			1986	36,791		40	1,054		19,567	15
16	Building Improvements - Brandel Care Center			1987	17,303		40	596		10,430	16
17	Building Improvements - Brandel Care Center			1988	30,032		40				17
18	Building Improvements - Brandel Care Center			1989	472,871		40	12,528		194,243	18
19	Building Improvements - Brandel Care Center			1989	115,230		40	3,046		44,167	19
20	Building Improvements - Brandel Care Center			1990	77,922		40	858		10,732	20
21	Building Improvements - Brandel Care Center			1991	25,051		40	105		1,425	21
22	Building Improvements - Brandel Care Center			1992	7,901		40	449		5,170	22
23	Building Improvements - Brandel Care Center			1994	19,938		40	425		4,458	23
24	52 pairs of shear and rods - all patient rooms			1997	8,000		40	599		4,491	24
25	14 Cubicle curtains - wings 100 & 200			1997	2,636		40	311		2,645	25
26	A/C equipment			1998	3,549		20	197		1,281	26
27	Room Remodeling			1999	2,989		20				27
28	Window treatments			1999	29,864		20				28
29	Heating A/C work			1999	1,665		20				29
30	New light fixtures			1999	1,647		20				30
31	hall door replacement			1999	329		20				31
32	Roof repair/replacement			1999	133,950		20	9,006		49,534	32
33	New bathrooms			2000	9,685						33
34	Renovation/modernization - consulting fees, design			2000	39,980						34
35	architectural fees			2000	41,630						35
36	development cost - other			2000	41,531						36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/2003 Ending: 01/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Renovation/modernization - primary architect fees	2000	$ 278,453	$		$	$	$	37
38	inspection - testing fees	2000	3,143						38
39	architect/engineering - other	2000	3,615						39
40	building permits	2000	33,347						40
41	misc. city/count/state fees	2000	9,775						41
42	Village of Northbrook fees	2000	80						42
43	legal	2000	32,405						43
44	site work	2000	180,808						44
45	foundation/slab	2000	94,988						45
46	building costs	2000	2,875,182		40	14,785		1,064,129	46
47	job services	2000	364,637						47
48	other	2000	13,693						48
49	Alarm units	2000	2,204						49
50	Consturciton fee	2000	69,822		20	10,216		35,757	50
51	Remodel wings 200 and 400	2001	123,129		20	10,216		15,390	51
52	Closed circuit T.V. monitoring system	2003	5,576		20				52
53	Remodel residents rooms 400 wing	2003	16,375		20	1,097		1,646	53
54	New Hot water boiler for Brandel	2004	29,187		20				54
55	Resident room door replacement	2004	48,247		20	1,935		1,935	55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,043,759	$		$ 111,303	$	$ 1,118,857	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/2003 Ending: 01/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,043,759	$		$ 111,303	$	$ 1,118,857	1
2									2
3	Brandel land improvements	1982	372,026					372,026	3
4	Brandel land improvements	1985	40,541			(430)		40,541	4
5	Brandel land improvements	1987	665			33		582	5
6	Brandel land improvements	1989	1,500			75		1,163	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20	Building Improvements - Axelson Manor	1987	9,537						20
21	Building Improvements - Axelson Manor	1988	11,898						21
22	Building Improvements - Axelson Manor	1989	25,256						22
23	Building Improvements - Axelson Manor	1990	6,612						23
24	Building Improvements - Axelson Manor	1991	5,581		20	3,964		49,549	24
25	Building Improvements - Axelson Manor	1992	10,312						25
26	Building Improvements - Axelson Manor	1993	10,084						26
27	Building Improvements - Axelson Manor	1994	11,446		20	572		6,008	27
28	Building Improvements - Axelson Manor	1995	4,965		20	284		2,394	28
29	Padding and carpeting	1996	3,410		20	263		2,238	29
30	Drapes and shears	1996	1,857						30
31	Carpet	1997	11,718		20	883		6,625	31
32	Food service renovations	1997	5,951						32
33	New building - Consulting fees, design & concept phase	1998	17,722						33
34	TOTAL (lines 1 thru 33)		$ 7,594,840	$		$ 116,947	$	$ 1,599,983	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/2003 Ending: 01/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 7,594,840	$		$ 116,947	$	$ 1,599,983	1
2	property concept/development cost	1998	13,384						2
3	primary architect fees	1998	179,191						3
4	collaborative architect rep fee	1998	215						4
5	inspection/testing fees	1998	1,701						5
6	architect and engineering, other	1998	2,675						6
7	building permits	1998	15,955						7
8	miscellaneous city/county/state fees	1998	2,221						8
9	fees and permits, other	1998	40						9
10	legal	1998	4,147						10
11	site work	1998	171,849						11
12	foundation/slab	1998	112,341						12
13	construction costs	1998	1,309,646		40	136,053		334,793	13
14	job services	1998	173,015		20	5,884		32,365	14
15	construction fee	1998	38,797						15
16	New building - construction expenditures, other	1988	10,890						16
17	other	1998	6,480						17
18	New carpet	1999	6,817						18
19	drapes/Shears for room	1999	554						19
20	New Roof	1999	38,000						20
21	Additional construction - architects fees	1999	2,416						21
22	Construction costs	1999	69,907						22
23	Floor covering	2000	3,308		20	443		1,995	23
24	Remodel Patio/Entrance	2001	20,000						24
25	Carpet Replacement - Common Areas	2001	2,665						25
26	Drapery Replacement - Common Areas	2001	269						26
27	Paving Entrance / Parking Lot	2001	36,342		20	165		578	27
28	Remodel Patio/Entrance	2001	8,547						28
29	Remodel Patio/Entrance	2001	940						29
30	Remodel Patio/Entrance	2001	20,697						30
31	Remodel Patio/Entrance	2001	4,575						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,852,424	$		$ 259,492	$	$ 1,969,714	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/2003 Ending: 01/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 9,852,424	$		$ 259,492	$	$ 1,969,714	1
2	Remodel residents bathrooms	2002	21,111			4,701		11,753	2
3	Carpet replacement 19 rooms	2002	13,609						3
4	Remodel residents bathrooms	2003	44,098			2,871		4,306	4
5	Carpet replacement	2003	6,484						5
6	A/C work	2003	1,467						6
7	Electrical work activities room	2003	2,025						7
8	Remodel fountain area	2003	7,025						8
9	Remodel residents bathrooms	2004	52,417			2,231		2,231	9
10	Replace doors in resident's rooms	2004	14,609						10
11	Remodel residents rooms	2004	22,221						11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,037,490	$		$ 269,295	$	$ 1,988,004	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/2003 Ending: 01/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 10,037,490	$		$ 269,295	$	$ 1,988,004	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,037,490	$		$ 269,295	$	$ 1,988,004	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/2003 Ending: 01/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 10,037,490	$		$ 269,295	$	$ 1,988,004	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,037,490	$		$ 269,295	$	$ 1,988,004	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/2003 Ending: 01/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,085,476	$	$ 90,959	$ 90,959		$ 557,504	71
72	Current Year Purchases	85,146						72
73	Fully Depreciated Assets	(83,163)						73
74								74
75	TOTALS	$ 1,087,459	$	$ 90,959	$ 90,959		$ 557,504	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Residential Transport	Bus	2000	$ 14,034	$	$ 2,806	$ 2,806		$ 12,821	76
77										77
78										78
79										79
80	TOTALS			$ 14,034	$	$ 2,806	$ 2,806		$ 12,821	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,209,255	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 363,060	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,558,329	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/2003 Ending: 01/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/2003 Ending: 01/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10-3	1060	hrs	$ 53,106		$	$	1,060	$ 53,106	1
2	Licensed Speech and Language Development Therapist	10-3	290	hrs	23,189				290	23,189	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10-3	1122	hrs	56,096				1,122	56,096	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy			# of prescrpts	497,804					497,804	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): Inhouse PT Therapist	10-a-1	1320		48,125				1,320	48,125	13
14	TOTAL				$ 678,320		$	$	3,792	$ 678,320	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/2003 Ending: 01/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 01/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 50,837	$ 3,240,311	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (10,867))	552,786	12,698,387	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		2,105,071	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		5,467,091	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 603,623	$ 23,510,860	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,309,589		12
13	Land	112,978		13
14	Buildings, at Historical Cost	11,567,578	543,836,211	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,087,459		16
17	Accumulated Depreciation (book methods)	(5,067,626)	(169,246,737)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		169,432,727	21
22	Other Long-Term Assets (specify):	5,378,151	23,827,025	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 14,388,129	$ 567,849,226	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 14,991,752	$ 591,360,086	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 90,665	$ 11,062,086	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		4,104,296	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	395,072	4,995,277	30
31	Accrued Taxes Payable (excluding real estate taxes)	328	1,337,454	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		2,095,721	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Current Maturities Ltd.		4,755,664	36
37			1,910,939	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 486,065	$ 30,261,437	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		275,877,590	39
40	Mortgage Payable			40
41	Bonds Payable	4,557,370		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Interco Accts	(7,959,609)	4,288,942	43
44			17,036,698	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (3,402,239)	$ 297,203,230	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (2,916,174)	$ 327,464,667	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 17,907,926	$ 263,895,419	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 14,991,752	$ 591,360,086	48

***(See instructions.)**

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/2003 Ending: 01/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 16,578,662	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 16,578,662	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,329,264	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,329,264	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 17,907,926	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/2003 Ending: 01/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,094,784	1
2	Discounts and Allowances for all Levels	(860,415)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,234,369	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	483,122	6
7	Oxygen	6,360	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 489,482	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	71,814	13
14	Non-Patient Meals	21,021	14
15	Telephone, Television and Radio	470	15
16	Rental of Facility Space		16
17	Sale of Drugs	563,573	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	9,667	20
21	Other Medical Services	206,936	21
22	Laundry	55,320	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 928,801	23
	D. Non-Operating Revenue		
24	Contributions	61,165	24
25	Interest and Other Investment Income***	113,942	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 113,942	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,766,594	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,817,718	31
32	Health Care	3,347,347	32
33	General Administration	2,243,543	33
	B. Capital Expense		
34	Ownership	427,406	34
	C. Ancillary Expense		
35	Special Cost Centers	601,316	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,437,330	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,329,264	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,329,264	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/2003 Ending: 01/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,425	1,581	$ 58,405	$ 36.94	1
2	Assistant Director of Nursing	2,135	2,337	56,698	24.26	2
3	Registered Nurses	31,420	34,076	816,132	23.95	3
4	Licensed Practical Nurses	3,995	4,174	77,234	18.50	4
5	Nurse Aides & Orderlies	120,001	122,651	1,686,461	13.75	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	985	1,320	48,125	36.46	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,268	10,526	143,786	13.66	10
11	Social Service Workers	6,421	7,211	140,245	19.45	11
12	Dietician					12
13	Food Service Supervisor	3,824	4,050	88,367	21.82	13
14	Head Cook					14
15	Cook Helpers/Assistants	31,456	32,799	336,195	10.25	15
16	Dishwashers					16
17	Maintenance Workers	4,139	4,637	111,499	24.05	17
18	Housekeepers	15,926	16,297	187,578	11.51	18
19	Laundry	2,133	2,428	24,166	9.95	19
20	Administrator	2,688	3,086	131,619	42.65	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,259	14,327	252,599	17.63	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Beauty shop		3,108	46,500	14.96	33
34	TOTAL (lines 1 - 33)	250,075	264,608	$ 4,205,609 *	$ 15.89	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	40	$ 1,645	1-3	35
36	Medical Director	Monthly	24,420	9-3	36
37	Medical Records Consultant	50	5,025	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,992	10-3	39
40	Physical Therapy Consultant	1,122	56,096	10a-3	40
41	Occupational Therapy Consultant	1,060	53,106	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	290	23,200	10a-3	43
44	Activity Consultant		3,795	11-3	44
45	Social Service Consultant	120	1,700	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,682	$ 170,979		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/2003 Ending: 01/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Duane Myers	Administrator	0%	$ 73,500
Paul D. Peterson	Administrator	0%	28,500
Neil Warnygora	Administrator	0%	29,620
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 131,620

B. Administrative - Other

Description	Amount
CRC Management Services	$ 422,568
TOTAL (agree to Schedule V, line 17, col. 3)	$ 422,568
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Deloitte & Touche,	Audit Services	$ 12,862
ADP	Payroll Services	10,325
Covenant Retirement Comm	Data Processing	21,468
Seabury & Smith	Benefits consultant	4,504
CTS	Healthcare Consult	3,169
FR &R	Healthcare Consult	75
Healthcare Consult Net	Healthcare Consult	769
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 53,172

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 99,136
Unemployment Compensation Insurance	7,926
FICA Taxes	260,126
Employee Health Insurance	512,270
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Group Life Ins	20,040
Pension Plan	14,184
Other	6,403
TOTAL (agree to Schedule V, line 22, col.8)	$ 920,085

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	754
Health Care Worker Background Check	1,532
(Indicate # of checks performed)	
LSN	7,477
Newpapers, magizines	1,533
Marketing	6,592
Licenses & Permits	1,034
Less: Public Relations Expense	( )
Non-allowable advertising	(6,592)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,330

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 307
In-State Travel	
Seminar Expense	2,275
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,582

**See instructions.

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/2003 Ending: 01/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 **Report Period Beginning:** 02/01/2003 **Ending:** 01/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? _____
If YES, give association name and amount. LSN 7477

(3) Did the nursing home make political contributions or payments to a politica
action organization? No If YES, have these costs
been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? No If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ 50,040 Line 10

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? _____
If YES, give effective date of lease. No

(9) Are you presently operating under a sublease agreement? NA YES _____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES _____ NO _____ If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
NA

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ 55,845
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? No For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ NA Has any meal income been offset against
related costs? Yes Indicate the amount. $ 21,022

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? NO If YES, please indicate the amount of income earned from such a
program during this reporting period. $ NA
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? _____
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $ NA

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: Deloitte & Touche, LLP The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? YES If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? NA
Attach invoices and a summary of services for all architect and appraisal fees.